DEPARTMENT OF HEALTH AND MENTAL HYGIENE

Behavioral Health Financing State/Local Role and Non-Medicaid Workgroup

Thank you for joining this live online broadcast of the Behavioral Health Financing State/Local Role and Non-Medicaid Workgroup Meeting. The meeting is scheduled to begin at 2:30 p.m. and conclude at 4:30 p.m. All attendees of the webinar will be in listen-only mode for the duration of the broadcast. Please submit questions using the Questions box on the side of your screen. We will address as many as possible during the Question and Answer session at the end of the meeting.

If you're having difficulty hearing the meeting, please alert us by raising your hand using the icon and we'll work to fix it as quickly as possible. Otherwise, please keep your hand down and use the Questions box to communicate with us.

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Behavioral Health Financing State/Local Role and Non-Medicaid Workgroup

Meeting 1

Tuesday – May 8, 2012

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Agenda

- Webinar Ground Rules
- Workgroup Charge
- Workgroup Timeline
- Financing Options
- State Role
- Local Role
  - David Goldman, Baltimore Co. Dept of Health
  - Donna Wells, Howard Co. CSA
- Discussion & Questions

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Webinar Ground Rules

- All presentations first
- Q & A following presentations
  - Webinar participants: please use the chat feature on your webinar screen to ask questions
  - If you're having difficulty hearing the meeting, please alert us by raising your hand using the  icon

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State/Local Role and Non-Medicaid Workgroup Charge

To make a recommendation on what services/ financing should be left outside a "Medicaid" integrated care model to accommodate non-Medicaid eligible populations, or non-Medicaid-eligible services. This Workgroup will also make a recommendation on the roles that state and local government should perform depending on which services/financing are left outside of the Medicaid financing model, as well as how to support and interface with selected model.

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Workgroup Timeline

- Workgroup reports due end August/early September to inform the Final report due September 30
- 4 meetings between May and August
  - May 8 2:30-4:40pm
  - June 13 1:30-3:30pm
  - July 11 1:00-3:00pm
  - August 21 1:00-3:00pm

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Financing Options

- Potential Models:
  1. Protected Carve-In
  2. Risk-based Carve Out
  3. Risk-based Population Carve-Out
- What will any of these models mean for our current state and local roles?

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ADAA Overview

- Responsible for planning, coordination, and regulation of the statewide network of substance abuse prevention, treatment, and recovery services
- Provides fiscal management and technical assistance to 24 jurisdictions who either purchase and/or provide services.
- Serves as a resource for information about substances of abuse as well as prevention, treatment, and recovery services available in the community

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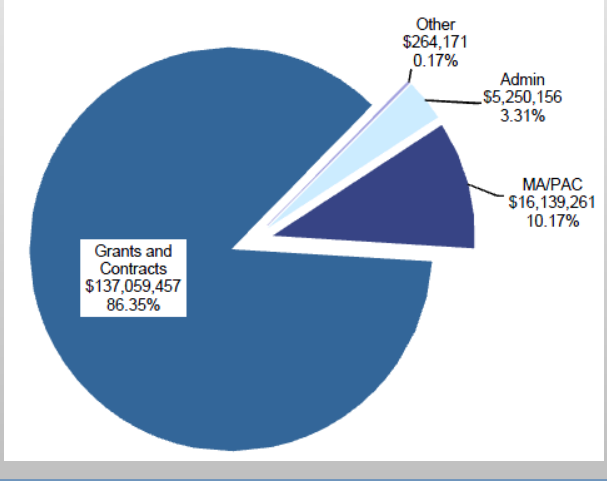
ADAA Fiscal 2013 Expenditure Categories



Grants and contracts comprise the majority of ADAA's spending, with these expenditures supporting substance abuse prevention, treatment, and recovery services.

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MHA Overview

- MHA operates and oversees the Public Mental Health System (PMHS):
  - Five state hospitals (mostly forensic population)
  - Two Regional Institutes for Children and Adolescents
  - Community Mental Health Providers
    - Outpatient Programs
    - Ongoing rehabilitative services (PRP, RRP)
    - Crisis Services
    - 1915(c) Waiver Services: Traumatic Brain Injury and Residential Treatment Facility (children and adolescents)

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Financing PMHS Services

- "Specialty" mental health services have been delivered through a "carve-out" arrangement since the beginning of the Medicaid HealthChoice Waiver in 1997 (and now PAC).
- Providers are paid on a fee for service basis.
- MHA is assisted by an Administrative Services Organization (ASO), which operates under a contract with MHA.
- The ASO, ValueOptions, authorizes services and provides utilization management, claims processing, evaluation services, and collects data.

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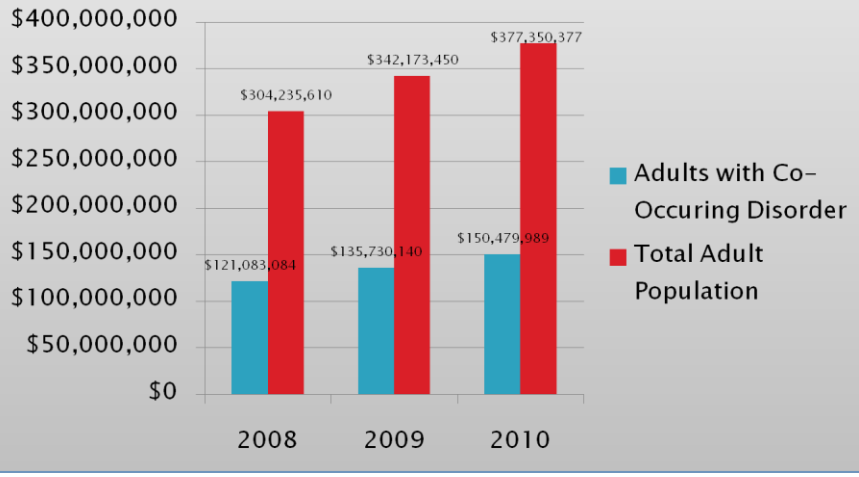
PMHS Expenditures for Adults with Co-Occurring Disorders



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Medicaid MCO Overview

- Currently, seven MCOs serve over 715,000 enrollees, (about 80%) of Medicaid enrollees
- MCOs receive a monthly capitation payment for each enrollee
  - Benefit package includes substance abuse services and mental health services provided by PCPs
- 33% of services are carved-out of HealthChoice and available on a fee-for-service (FFS) basis - including specialty mental health
- Enrollees in managed care can self refer for substance abuse services

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Local Role – Addictions Treatment Coordinators

David Goldman, LCSW-C
Chief, Bureau of Behavioral Health
Baltimore County Department of Health

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Substance Abuse Treatment Coordination Today

- Drug and Alcohol Abuse Council Starts the Process:
  - Needs Assessment, Plan, Outcomes
- Service Delivery
- Procurement, Grants Management
- Quality Assurance/Monitoring
- Consumer/Family Services
- Technical Assistance/Training

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Current Treatment Access

- Third Party Insurance
- Medical Assistance/PAC
- Uninsured (DHMH approved sliding fee scale)
- Services Not Covered by above:
  - Social Drinkers Education
  - Evaluations (Legal)
  - Some Drug Testing

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MA Substance Abuse Services Today for MA Consumers

- Outpatient Treatment (Level I)
- Intensive Outpatient Services (Level II.1/II.5)
- Methadone
- Suboxone/Buprenorphine (but not specialist visit for PAC)
- Urinalysis

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Non MA Substance Abuse Services Today for MA Consumers

- Residential Treatment (may include Detox) Level III:
  - Low Intensity III.1
  - Medium Intensity III.3
  - High Intensity III.5
  - Medically Monitored Inpatient III.7

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Non MA Substance Abuse Services Today for MA Consumers

- Prevention/Education in Community/Schools
- Alternative Programs
- Juvenile Drug Court
- Family Recovery Court
- Court Evaluations (HG-505/507)
- EBP programs (BSFT/FFT)

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Non MA Substance Abuse Services Today for MA Consumers

- Gambling Counseling
- Tobacco Assessment/Referral
- Recovery oriented Systems of Care
- Care Coordination
- Access to Recovery
- Information/Referral
- Community Reinforcement and Family Training (CRAFFT)

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Local Role – Mental Hygiene's Core Service Agencies

MACSA
Maryland Association of Core Service Agencies

Donna Wells
Howard Co. CSA

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MACSA Mission and Vision

- **Mission:** To promote wellness by improving behavioral health in Maryland through collaborative partnerships.
- **Vision:** To have a comprehensive, effective and responsive service delivery system that assists Marylanders in achieving optimum wellness and recovery.

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Shared Values

- Wellness and Recovery Oriented
- Individualized and Self Directed with Consumer Choice
- High Quality, Cost Effective and Accessible
- Integrated and Community Based
- Collaborative and Interagency in Focus
- Innovative and Comprehensive

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CSA Function

- Core Service Agencies (CSAs) **plan, develop** and **manage** a full range of treatment and rehabilitation services for persons with serious mental illnesses.
- They collaborate with other human service agencies to promote comprehensive services for individuals with mental illness who have multiple human needs.
- Core Service Agencies promote wellness by improving behavioral health in Maryland through collaborative partnerships.

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CSA Structure

- There are **19 CSAs in Maryland**. Wicomico and Somerset are regional, as are Dorchester, Talbot, Caroline, Queen Anne's and Kent (Mid Shore CSA)
- 9 CSAs are **Health Department**, 3 are **government**, 1 is **quasi government**, 6 are **private non-profits**.
- The total cost of the CSAs represented **less than 2% of the total cost of the PMHS**.
- Each CSA, while having the same legal mandate, operates in a manner **unique to the jurisdiction it serves**, based on local needs, innovation and availability of human and fiscal resources.

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CSAs' MOU with the State

It is the policy of DHMH to empower local jurisdiction's CSA to plan, manage, deliver where applicable, and monitor the implementation of publicly funded local mental health services, including those paid under contract with state general funds and/or federal funds, as well as those funded under the Fee-for-Service (FFS) of the Public Mental Health System (PMHS.)

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CSAs' MOU continued

Develop and maintain an integrated system of publicly funded mental health services, which is responsive to the needs of the consumers and providers in its jurisdiction. The CSA shall make all reasonable efforts to coordinate the activities of publicly funded Fee-for-Service vendors providing mental health services.

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A Snapshot of CSA Functions

- **596** non Fee-For-Service contracts monitored
- **$67,079,396** non Fee-For-Service funds managed
- **3,066** residential beds monitored
- **420** public education events and trainings sponsored
- **196** complaints resolved (of 201)
- **59,892** help, referral, and crisis calls answered
- **543** adults transitioned from inpatient services
- **241** children diverted from residential placement

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Current CSA Roles

- System Oversight
- Quality Assurance / Accountability
- Reporting / System Analysis
- System Navigation
- Consumer Care / Services
- Cooperation / Partnering
- Disaster Planning and Preparedness
- Consumer Information / Public Education
- Innovation

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Contact Us

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Discussion & Questions

Q: What do you think the local role should be after BH integration?

Questions and Comments?

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BH Integration Email & Comments

- To get on the Behavioral Health Integration e-mail list, write to bhintegration@dhmh.state.md.us
- All comments regarding the State/Local Role & Non-Medicaid Workgroup should be sent to the above email with "State/Local" in the subject line.